P A T H

Department of Prevention, Assistance, Transition, and Health Access

B U L L E T I N N O. 00-31F

FROM Eileen I. Elliott, Commissioner
for the Secretary

DATE: 10/05/01

SUBJECTS Medicaid Policy Revisions for Outpatient Hospital Services and Payment, Mental Health Benefits, Surgical Benefits, Hearing Aids, Orthodontic Treatment, Acupuncture, and Prescription Drugs; and the Addition of Policy Regarding Massage Therapy and Fertility Services

CHANGES ADOPTED EFFECTIVE 11/1/01

INSTRUCTIONS

X **Maintain Manual - See instructions below.**

___ **Proposed Regulation - Retain bulletin and attachments until you receive Manual Maintenance Bulletin:**

___ **Information or Instructions - Retain until** _____

MANUAL REFERENCE(S)

M520	M614	M622	M812
M611	M615	M650	
M612	M616	M660	
M613	M618	M811	

This bulletin modifies Medicaid policy in selected areas, including outpatient hospital services and payment, mental health benefits, surgical benefits, hearing aids, orthodontic treatment, acupuncture, and prescription drugs. It also adds policy regarding massage therapy and fertility services. The content of this bulletin reflects changes in technology, department practice, terminology, and state laws.

Specific Changes Include:

M520 Outpatient Hospital Services. The revised policy incorporates the PP &D dated July 1, 1999, which adds diabetic counseling or education services and coverage of one membership in the American Diabetes Association (ADA) per lifetime, per beneficiary. In addition, conditions under which prior authorization for therapy services beyond one year from the onset of treatment will be granted has been referenced to policy at M710.5, which was previously adopted by the department on April 1, 1999. Policy regarding emergency room use and care has been referenced to policy at M103.3 (a) (13), which was adopted previously by the department on July 1, 1999. Payment for outpatient hospital services has been revised to be in compliance with the Vermont Medicaid State Plan.

In response to the expressed concerns of members of the Legislative Committee on Administrative Rules, PATH modified the final proposed rule by adding language that allows beneficiaries to receive more than 12 visits with a diabetic educator with prior authorization.

M611 Psychiatric Services. This policy has been modified to comply with the Mental Health Parity Law, Act 25 (1997), and to reflect the department's current practice. Since the first filing, the first sentence has been revised to clarify its meaning.

In response to the expressed concerns of members of the Legislative Committee on Administrative Rules, PATH modified the final proposed rule by clarifying what psychiatric services are and deleting all references to the Provider Manual and prior authorization.

M612 Intestinal Bypass Surgery. This policy has been deleted because the procedure is no longer considered experimental and may be covered with prior authorization.

M613 Covered Organ and Tissue Transplants. This policy has been modified to reference the list of current covered transplant procedures in the Provider Manual and changes "recipient" to "beneficiary" and "Medicaid Director" to "OVHA Director".

In response to the expressed concerns of members of the Legislative Committee on Administrative Rules, PATH modified the final proposed rule by clarifying the criteria for transplant services and deleting all references to the Provider Manual.

M613.1 Acupuncture. This policy has been moved to M618.

M614 Physician Visits. This policy changes references to Level I and ICF to NF (nursing facility) to update terminology. Since the first filing, this section has been revised to clarify that no change in benefits is intended.

M615 Cosmetic Surgery. This policy has been reformatted and renamed Surgery. In addition, policy has been added prohibiting Medicaid coverage for experimental and gender reassignment surgery.

In response to the expressed concerns of members of the Legislative Committee on Administrative Rules, PATH modified the final proposed rule by eliminating the prohibition on gender reassignment surgery.

M616 Sterilizations and Related Procedures. This policy changes "recipient" to "beneficiary."

M616.1 Fertility Services. This new policy section prohibits Medicaid coverage of fertility services, which reflects current department practice. Since the first filing, cloning has been added to the list of noncovered services.

M618 Acupuncture. This policy has been moved from M613.1. Previous language has been deleted, and language has been added prohibiting Medicaid coverage of acupuncture, which reflects the department's current practice.

M618.1 Massage Therapy. This policy has been added to articulate the department's current practice of prohibiting coverage of massage therapy.

M622.6 Noncovered Services. This policy has been deleted because it is not consistent with the conditions of coverage for orthodontic treatment.

In response to the expressed concerns of members of the Legislative Committee on Administrative Rules, PATH modified the final proposed rule by adding language indicating that orthodontic treatment may be approved by the department if found necessary under EPSDT.

M650.4 Conditions for Coverage. This policy was modified with the incorporation of language agreed upon by audiologists and the department.

In response to the expressed concerns of members of the Legislative Committee on Administrative Rules, PATH modified the final proposed rule by adding language indicating that hearing aids may be approved by the department if found necessary under EPSDT.

M660 Psychologists Practicing Independently. This policy has been modified to comply with the Mental Health Parity Law, Act 25 (1997), and to reflect the department's current practice.

In response to the expressed concerns of members of the Legislative Committee on Administrative Rules, PATH modified the final proposed rule by removing all references to the Provider Manual and prior authorization.

M811.2 Amphetamines and Appetite Depressants. This policy has been revised to reflect the department's current practice and includes coverage for nonamphetamine-based weight reduction drugs.

M812.1 Prescription Drugs for the Treatment of Sexual Dysfunction. This new policy limits the amount of prescription medication a beneficiary may receive per month when the primary purpose is treatment of erectile or sexual dysfunction. This new policy reflects the department's current practice.

In response to the expressed concerns of members of the Legislative Committee on Administrative Rules, PATH modified the final proposed rule by increasing the number of doseages of prescription of drugs for the treatment of sexual dysfunction from four to six tablets or injections per month, per beneficiary.

Since the first filing, minor changes, such as punctuation and spelling corrections, have been made to the proposed rule without affecting the substance of the rule.

A public hearing was held on February 12, 2001, at 1:00 p.m., in the Mad Tom Notch Room, Cyprian Learning Center, Waterbury State Office Complex. Two members of the public attended the hearing.

Written comments were received on behalf of a clinical psychologist, Disability Law Project of the Vermont Legal Aid, Vermont Coalition for Disability Rights (VCDR), the Office of Health Care Ombudsman, and three private individuals. The comments relevant to the proposed policy are summarized below. Other comments, on topics not specifically addressed by the proposed policy, are not summarized.

Written Summary of the Comments

M 520 *Outpatient Hospital Services*

Comment: One commenter asserts that the proposed standards for coverage of diabetic counseling and education services appear restrictive on the total number of visits and is inconsistent with Act 14 (1997-98), which does not limit the number of sessions and covers these services "if prescribed".

Response: The department respectfully disagrees with the commenter. The department believes the proposed regulations are consistent with the letter and spirit of Act 14 (1997-98), as well as the recommendations of Vermont Program for Quality in Health Care (VPQHC).

Comment: One commenter noted the proposed regulations needed to clearly state any prior authorization requirements for inhalation therapy beyond one year.

Response: At this time, the department has made no changes in coverage regarding inhalation therapy, and currently inhalation therapy provided as an outpatient hospital service does not require prior authorization.

M611 *Psychiatric Services*

Comment: One commenter noted that the first sentence of this regulation was not a complete sentence, so the intent of the regulation is not clear.

Response: The department agrees with the commenter and has modified the sentence to clarify its intent.

Comment: One commenter asserted that prior authorization requirements should be in the proposed regulations and that the department needs to make the provider manuals available as required by federal regulation and provide the provider updates to all manual holders.

Response: The department previously created a section on prior authorization that went through the Administrative Procedures Act process and was adopted in rule on April 1, 1999.

This policy is found at M106. Prior authorization is a utilization management measure that is specific to the requested service(s). The department is in the process of updating all of the provider manuals. Once updated the provider manuals will be available through the Internet.

M613 *Covered Organ and Tissue Transplants*

Comment: Two commenters do not support the proposed change to list the currently covered transplant procedures in the Provider Manual instead of the Medicaid Policy Manual. Both commenters noted that Provider Manuals have not been regularly updated in the past and, if the procedures are listed only in the Provider Manual, they have not gone through the Administrative Procedures Act. Such procedures are not readily available to individuals reviewing regulations, so there is no way of knowing if a service is covered or if there have been a cut in the services provided. In addition, one commenter believed that the first sentence in M613 is appropriate and will allow the department to add new services over time because it is important that beneficiaries have the right to request services that meet the criteria set by the first sentence that are not listed in the Provider Manual.

Response: The department is aware that the Provider Manual has not been available to all individuals and has not been updated on a regular basis. The department is in the process of updating all of the provider manuals. Once updated, the provider manuals will be available through the Internet. The department agrees that the first sentence in M613 does present the criteria for transplant procedures and believes that relocating the actual list of covered transplant procedures to the Provider Manual will not adversely effect a beneficiary who requests a transplant procedure not on the list in the Provider Manual. When this rule was originally adopted and when the list was created, organ transplants were relatively new and many procedures were still considered experimental. With the improvement and development of transplantation technology, many of the procedures once considered experimental are no longer so classified, making the list unnecessary. Putting the list in rule will inhibit the coverage of new procedures, as such procedures can only be added through the more time-consuming APA process.

M614 *Physician Visits*

Comment: One commenter noted that current regulations cover up to one physician visit per week for SNF (level I) and one visit per month for ICF (level II). The proposed regulation eliminates coverage for SNF visits. The department should explain the rationale if there is a reduction in covered services.

Response: The proposed rule updates the term SNF to nursing facilities (NF), which is the current term used to refer to SNFs and ICFs. This section has been further revised to clarify that no change in benefit was intended.

M615 *Surgery*

Comment: Five commenters opposed the department's proposed regulations regarding gender reassignment surgery. One commenter submitted various legal cases and arguments to support the view that excluding gender reassignment surgery from coverage is impermissible under federal law. One commenter stated that gender reassignment surgery is currently a covered service and requests that the department explain why it is eliminating coverage for gender reassignment. In addition, one commenter notes that the department has agreed to cover this procedure when it has been determined to be medically necessary and that the department should continue to provide coverage in those cases.

Response: The department has surveyed the other states on coverage of these procedures. Of the 27 states that responded, 24 said that they exclude coverage of gender reassignment surgery because it is not medically necessary. The majority of these state exclude gender reassignment surgery through program policy, code, state statute or state plan amendments approved by the Centers for Medicare and Medicaid Services (CMMS, formerly HCFA, the Health Care Financing Administration). CMMS has not issued any guidelines on gender reassignment surgery. Gender reassignment surgery is, in the department's view, essentially the removal of healthy tissue or organs and, as such, is not medically necessary. However, the M108 procedure is available to Medicaid beneficiaries who wish to request gender reassignment surgery. The department will continue to refer all Medicaid beneficiaries requesting gender reassignment surgery under the M108 process to the Sexual Behaviors Consultation Unit at Johns Hopkins for an independent review and recommendations.

For children with conditions requiring gender reassignment surgery, the procedure would be covered under the requirements of EPSDT.

M616.1 *Fertility Services*

Comment: One commenter noted that fertility services are not currently in regulation and asked if the department is eliminating fertility services from covered services.

Response: The department does not currently cover fertility services. However, since a number of beneficiaries have requested these services, the department has clarified that they are not covered.

M618 *Acupuncture*

Comment: One commenter noted that the current regulations state that acupuncture will not be covered until the National Institutes of Health (NIH) have assessed the use of acupuncture for anesthesia and relief of chronic pain. This commenter requested an explanation of the department's reasoning for deleting this language and for not covering acupuncture.

Response: Traditional Medicaid beneficiaries may request services not pre-approved for coverage through the M108 procedure. The department, however, chooses not to cover this optional service for all Medicaid beneficiaries due to budget constraints and ongoing concerns about the ability of the department to sustain the existing level of coverage.

M622 *Orthodontic Treatment*

Comment: With respect to the proposed clarification of coverage for a single malocclusion through the M108 procedure, one commenter said that it is important that this possibility not be eliminated for those children who may need orthodontic work for medical reasons other than malocclusions.

Response: The department removed the provision for coverage of a single malocclusion through the M108 procedure because this provision was inconsistent with policy found at M622.3, M622.4 and M108. Medically necessary orthodontic treatment for children is a covered service.

M650 *Audiology Services/Hearing Aids*

Comment: One commenter asserted that the proposed regulations change the standards for covering hearing aids. In addition, one commenter expressed concern that the proposed standards may not provide medically necessary hearing aids to pediatric patients with lesser degrees of hearing loss than those proposed in regulation.

Response: The department believes that the proposed rules clarify but do not change the guidelines for covering hearing aids. The department worked with a physician specialist and an audiologist who were concerned about the wording for the "Conditions for Coverage" section. They suggested modifications in this section to make the criteria consistent with current practice, and the department agreed to make the suggested changes. The decibel levels for hearing aids did not change. The department complies with all the requirements of EPSDT and provides medically necessary hearing aids to children.

M660 *Psychologists Practicing Independently*

Comment: One commenter asserted that the prior authorization requirements for this service be in regulation and not solely in the Provider Manual.

Response: The department believes that it would be inappropriate to put medical criteria for all services in rule because of the length of time involved in making a change through the Administrative Procedures Act and the need to be timely in the face of rapidly changing medical practice. The department is in the process of updating all of the provider manuals, which will be available through the Internet.

M811.4 *Other Preparations*

Comment: One commenter asserted that this regulation should clearly state where requests for prior approval should be sent because the proposed regulation refers to the Medicaid Division rather that to OVHA.

Response: The department agrees with the commenter and has made the recommended change.

M812.1 *Prescription Drugs for the Treatment of Sexual Dysfunction*

Comment: One individual at the public hearing and one individual submitting written comments asserted that the department's limitation on the number of dosages per month was too low and urged the department to increase the amount of coverage to reflect variation in the needs of beneficiaries.

Response: The department has approved four dosages (tablets or injections) per month per beneficiary of prescription drugs for the treatment of sexual dysfunction, after researching the amount that other states were providing to beneficiaries. The department believes that four dosages per month is a reasonable amount, based on the levels provided to beneficiaries in other state Medicaid programs.

The department has provided the Legislative Committee on Administrative Rules with a copy of a letter from the Health Care Financing Administration (now CMMS) authorizing the department to limit coverage of certain drugs.

Review by the Legislative Committee on Administrative Rules

The Legislative Committee on Administrative Rules (LCAR) considered the final proposed rule on 9/5 and 9/19 and it approved a change in the effective date for the adopted rule from 9/12/01 to 11/1/01.

In addition, PATH modified the final proposed rule as follows in response to the expressed concerns of members of the Legislative Committee on Administrative Rules:

- M520-the department has added a provision allowing beneficiaries to receive more than 12 visits with a diabetic educator with prior authorization,
- M611-the department clarified what psychiatric services are and deleting all references to the Provider Manual and prior authorization,
- M613-the department clarified the criteria for transplant services and deleting all references to the Provider Manual,
- M615-the department eliminated the prohibition on gender reassignment surgery,

- M622-the department added language indicating that orthodontic treatment may be approved by the department if found necessary under EPSDT,

- M650.4-the department added language indicating that hearing aids may be approved by the department if found necessary under EPSDT,

- M660-the department removed all references to the Provider Manual and prior authorization, and

- M812.1-the department increased the number of tablets or injections of medications for the treatment of sexual dysfunction from 4 to 6 per beneficiary, per month.

Vertical lines in the left margin indicate significant changes. Dotted lines at the left indicate changes to clarify, rearrange, correct references, etc., without changing regulation content.

MANUAL MAINTENANCE

MANUAL HOLDERS: Please maintain manuals assigned to you as follows. You will need both the proposed and the final Bulletin to maintain your manuals.

Medicaid Policy

Remove		Insert	
M520 P.1	(83-14)	M520	(00-31F)
M520 P.2	(91-31)	M520 P.2	(00-31F)
TOC P.1 (M600)	(98-11F)	TOC (M600)	(00-31F)
TOC P.2	(98-11F)	TOC P.2	(00-31F)
M611	(83-14)	M611	(00-31F)
M613	(89-73)	M613	(00-31F)
M613 P.2	(89-73F)	M613 P.2	(00-31F)
M614	(84-46)	M614	(00-31F)
M616	(83-14)	M616	(00-31F)
Nothing		M618	(00-31F)
M622	(98-11F)	M622	(00-31F)
M650	(99-12)	M650	(00-31F)
M650.4 P.2	(99-12)	M650.4 P.2	(00-31F)
M660	(85-1F)	M660	(00-31F)
TOC P.1 (M800)	(99-12F)	TOC (M800)	(00-31F)
M811.2	(90-35F)	M811.2	(00-31F)
Nothing		M811.4 P.2	(00-31F)
M812	(80-62)	M812	(00-31F)

M520 Outpatient Hospital Services

"Outpatient hospital services" are defined as those covered items and services indicated below when furnished in an institution meeting the hospital services provider criteria (M500), by or under the direction of a physician, to an eligible beneficiary who is not expected to occupy a bed overnight in the institution furnishing the service.

Covered items and services include:

- Use of facilities in connection with accidental injury or minor surgery. Treatment of accidental injury must be provided within 72 hours of the accident.

- Diagnostic tests given to determine the nature and severity of an illness; e.g., x-rays, pulmonary function tests, electrocardiograms, blood tests, urinalysis and kidney function tests.

- Diabetic counseling or education services; one diabetic education course per beneficiary per lifetime provided by a hospital-sponsored outpatient program, in addition to 12 diabetic counseling sessions per calendar year provided by a certified diabetic educator. Medicaid also covers one membership in the American Diabetes Association (ADA) per lifetime.

- Rehabilitative therapies (physical, occupational, speech, inhalation) related directly and specifically to an active written treatment plan established and periodically reviewed by the physician. The plan must be reasonable and necessary to the treatment of the individual's illness or injury; rehabilitative therapies will be routinely covered for the first four months on physician certification. Provision of therapy services (physical, speech or occupational) beyond the initial four-month period is subject to prior authorization review. To receive prior authorization for these services during the eight-month period immediately following the initial four-month period, a physician must submit a written request to the department with pertinent clinical data showing the need for continued treatment, projected goals and estimated length of time.

  Prior authorization for physical, speech, or occupational therapy services beyond one year from the onset of treatment will be granted only if the beneficiary meets the criteria found at M710.5.

- Emergency room care. Use of the emergency room at any time is limited to instances of emergency medical conditions, as defined in M103.3 (a)(13).

M520 Outpatient Hospital Services (Continued)

For all Vermont hospitals and the following New Hampshire hospitals (Dartmouth-Hitchcock, Cheshire, Valley Regional, Alice Peck Day, Cottage, Upper Connecticut Valley, Weeks Memorial, and Littleton Regional), payment is made on an interim basis at a hospital specific interim percentage of charge subject to year-end audit and cost-adjustment in accordance with the Title XVIII principles of Reasonable Cost Reimbursement (42 C.F.R. Part 413) with exceptions noted in the Vermont Medicaid State Plan.

All other hospitals will be reimbursed at the mean percentage of the interim rates for Vermont and the New Hampshire hospitals listed above for the services rendered with no year-end cost settlement.

M611 Psychiatric Services

Psychiatric services are physician's services for treatment of mental, psychoneurotic, or personality disorders, as defined in the American Psychiatric Association's "Diagnostic and Statistical Manual - Mental Disorders.

Continuing psychiatric services require prior authorization, as detailed in the Provider Manual. When requesting continuing services, a provider must submit a beneficiary's treatment plan to OVHA. The treatment plan must include the medical and psychiatric history of the patient, recommended course of treatment, anticipated number and frequency of services, and such other relevant information as will fully substantiate the request for continuing services.

M613 Covered Organ and Tissue Transplants

The organ transplantation services are covered when medically necessary and when not experimental or investigational. A list of organ transplant procedures currently covered is found in the Provider Manual.

Reimbursement will be made for medically necessary health care services provided to an eligible beneficiary or a live donor and for the harvesting, preservation, and transportation of cadaver organs.

Prior Authorization

Authorization prior to the initiation of services must be obtained from the Office of Vermont Health Access (OVHA) or its designated review agent.

This requirement is administered to assure that organ transplant requests are treated consistently; similarly situated beneficiaries are treated alike; any restriction on the facilities or practitioners that may provide service is consistent with the accessibility of high quality care to eligible beneficiaries; and services for which reimbursement will be made are sufficient in amount, duration, and scope to achieve their purpose.

Standards for Coverage

OVHA or its designated review agent must receive from the beneficiary's attending or referring physician and the transplant center physician the following assurances:

1. The Medicaid beneficiary has a condition for which organ transplantation is the appropriate treatment.

2. All other medically feasible forms of medical or surgical treatment have been considered, and the most effective and appropriate medically indicated alternative for the beneficiary is organ transplantation.

3. The Medicaid beneficiary meets all medical criteria for the proposed type of organ transplantation based upon the prevailing standards and current practices. These would include, but are not limited to:

    a. Test lab results within identified limits to assure successful transplantation and recovery.
    b. Diagnostic evaluations of the beneficiary's medical and mental conditions that indicate there will be no significant adverse effect upon the outcome of the transplantation.
    c. Assessment of other relevant factors that might affect the clinical outcome or adherence to an immunosuppressive regimen and rehabilitation program following the transplant.

M613 Covered Organ and Tissue Transplants (Continued)

d. The beneficiary or the beneficiary's parent or guardian or spouse has been fully informed of the risks and benefits of the proposed transplant including the risks of complications, continuing care requirements, and the expected quality of life after the procedure.

4. The transplant center meets the following criteria:

a. Fully certified as a transplant center by applicable state and federal agencies.

b. Is in compliance will all applicable state and federal laws which apply to organ acquisition and transplantation including equal access and non-discrimination.

c. Has an interdisciplinary team to determine the suitability of candidates for transplantation on an equitable basis.

d. Provides surgeons who have a minimum of one year of training and experience appropriate to the organ being transplanted which includes experience in transplant surgery, post-operative care and management of an immunosuppressive regimen.

e. At the time Medicaid coverage is requested the center must have performed at least ten transplants of the type requested during the previous twelve months and must provide current documentation that it provides high quality care relative to other transplant centers.

f. Provides all medically necessary services required including management of complications of the transplantation and late infection and rejection episodes. Failure of the transplant is considered a complication and re-transplantation is available at the center.

Liability of Other Parties

Medicaid is always the payer of last resort. Medicare and other insurance coverage for which a Medicaid beneficiary is eligible must discharge liability before a claim for payment will be accepted. Coinsurance and deductible amounts will be paid in an amount not to exceed the Medicaid rate for the service.

Any additional charges made to a beneficiary or beneficiary's family after payment by Medicaid is supplementation and is prohibited.

Providers of health care services specifically funded by research or grant monies may not make claim for payment.

M614 Physician Visits

Reimbursement for physician visits will be made in the following manner:

Office visits - up to five visits per month;

Home visits - up to five visits per month;

Nursing facility visits - up to one visit per month;

Hospital visits - up to one visit per day for acute care, or after denial for acute care by utilization review, up to one visit per month for subacute care.

Visits in excess of those listed above can be reimbursed if there is a significant change in the health status of the patient that requires more frequent visits.

Payment for concurrent care will be limited to one practitioner unless it can be demonstrated that such care is part of a coordinated treatment plan.

Payment for surgery services includes normal postoperative care for 30 days following the surgery.

M615 Surgery

1. Cosmetic Surgery

Cosmetic surgery and expenses incurred in connection with such surgery are not covered. Cosmetic surgery encompasses any surgical procedure directed at improving appearance (including removal of tattoos), except when required for the prompt repair of accidental injury or the improvement of the functioning of a malformed body member. For example, the exclusion does not apply (and payment would be made) for surgery in connection with treatment of severe burns or repair of the face following an auto accident or for surgery for therapeutic purposes that coincidentally serves some cosmetic purpose. In questionable cases, authorization prior to performing surgery should be requested from OVHA.

2. Experimental Surgery

Experimental surgery and expenses incurred in connection with such surgery are not covered. Experimental surgery encompasses any surgical procedure not proven to be clinically efficacious by literature and experts in the field.

3. Gender Reassignment Surgery

Gender reassignment surgery and expenses incurred in connection with such surgery are not covered.

M6l6 Sterilizations and Related Procedures

Sterilization of either a male or female beneficiary is covered only when the following conditions are met:

The beneficiary has voluntarily given informed consent and has so certified by signing the consent form included in DHEW Publication No. (OS)79-5006l (Female), or (OS)79-50062 (Male), November, l978 and provided by the Department of Prevention, Assistance, Transition, and Health Access.

The beneficiary is not mentally incompetent.

The beneficiary is at least 2l years old at the time consent is obtained.

At least 31 days but not more than l80 days have passed between the date of informed consent and the date of sterilization except in the case of premature delivery or emergency abdominal surgery. In those cases, at least 72 hours must have passed between the informed consent and the operation.

Operations or procedures preformed for the purpose of reversing or attempting to reverse the effects of any sterilization procedure are not covered.

A hysterectomy is not covered if:

It was performed solely for the purpose of rendering an individual incapable of reproducing; or

If there was more than one purpose to the procedure, it would not have been performed but for the purpose of rendering the individual permanently incapable of reproducing; or

Any other hysterectomy is covered only if the beneficiary has been informed as to the nature of the operation and its consequences and has given her consent by signing the Hysterectomy Consent Form (DSW 2l9C).

M616.1 Fertility Services

Fertility services and procedures performed in connection with such services are not covered. Noncovered fertility services include, but are not limited to, in vitro, the GIFT procedure, fertility enhancing drugs, sperm banks, cloning, and services related to surrogacy.

M618 Acupuncture

Acupuncture and services performed in connection with acupuncture are not covered.

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M618.1 Massage Therapy

Massage therapy and services performed in connection with massage therapy are not covered.

M622 Orthodontic Treatment

M622.1 Definition

Medically necessary orthodontic treatment involves the use of one or more prosthetic devices to correct a severe malocclusion. This definition is consistent with the federal definition found at 42 CFR §440.120(c).

M622.2 Eligibility for Care

Coverage for orthodontic treatment is limited to beneficiaries under the age of 21.

M622.3 Covered Services

Services that have been pre-approved for coverage are limited to medically necessary orthodontic treatment, as defined in M622.4.

M622.4 Conditions for Coverage

To be considered medically necessary, the beneficiary's condition must have one major or two minor malocclusions according to diagnostic criteria adopted by the department's dental consultant.

Approval granted by the department's dental consultant assures medical necessity only. All other program requirements must also be met to assure payment.

M622.5 Prior Authorization Requirements

Prior authorization is required for interceptive and comprehensive orthodontic treatment.

M622.6 [Reserved]

M650 Audiology Services/Hearing Aids

M650.1 Definition

Audiology services are those services requiring the application of theories, principles and procedures related to hearing and hearing disorders for the purpose of diagnosis, screening, prevention and correction. This definition is consistent with the federal definition found at 42 CFR §440.110(c).

M650.2 Eligibility for Care

Coverage of audiology services is provided to beneficiaries of any age.

M650.3 Covered Services

Audiology services that have been pre-approved for coverage are limited to:

- Audiologic examinations;
- Hearing screening;
- Hearing assessments;
- Diagnostic tests for hearing loss;
- Analog hearing aids, plus their repair or replacement for beneficiaries of any age;
- Digital hearing aids, plus their repair or replacement for beneficiaries under age 21;
- Prescriptions for hearing aid batteries - six batteries per month;
- Fitting/orientation/checking of hearing aids; and,
- Ear molds.

M650.4 Conditions for Coverage

Payment will be made for hearing aids for beneficiaries who have at least one of the following conditions:

1. Hearing loss in the better ear is greater than 30dB based on an average taken at 500, 1000, and 2000Hz.

2. Unilateral hearing loss is greater than 30dB, based on an average taken at 500, 1000, and 2000Hz.

M650.4 Conditions for Coverage (Continued)

3. Hearing loss in the better ear is greater than 40dB base on an average taken at 2000, 3000, and 4000Hz, or word recognition is poorer than 72 percent.

M650.5 Prior Authorization Requirements

Prior authorization is required for more than one hearing aid repair per year or any repair in excess of $100.

M650.6 Noncovered Services

Unless authorized for coverage via M108, nonmedical items, such as canal aids and maintenance items other than batteries, and fees associated with selection trial periods or loaners are not covered.

Unless authorized for coverage via M108, digital hearing aids are not covered for beneficiaries age 21 or older.

M650.7 Qualified Providers

Audiology services must be provided by a physician or an audiologist who has a certificate of clinical competence from the American Speech and Hearing Association or who has the equivalent education and experience to acquire the certificate or who has completed an academic program and is acquiring supervised work experience to qualify for the certificate. The provider must also be enrolled with Vermont Medicaid.

M650.8 Reimbursement

Reimbursement for audiology services is described in the Provider Manual.

M660 Psychologists Practicing Independently

Diagnostic tests performed by a qualified Vermont psychologist practicing independently of an institution, agency, or physician's office are covered. A "qualified" psychologist is one practicing in the state who has been approved for participation in Medicare by the Part B Carrier or who is licensed in accordance with 26 V.S.A. Chapter 55.

Psychotherapy or diagnostic tests provided by a psychologist practicing independently to an inpatient or outpatient of general hospital or mental hospital or in a community mental health clinic are not covered.

Diagnostic psychological services performed by qualified independent psychologists are paid on the basis of reasonable charges. Where the billing is based on the number or length of sessions involved, payment will be at the lesser of actual charge or the Medicaid reimbursement rate on file. The psychological evaluation includes interviewing, testing, scoring, evaluation and a written report. Payment will be made for any deductible or coinsurance remaining after the application of Medicare Part B benefits at the rates established under that program for diagnostic testing services.

Continuing psychological services require prior authorization, as detailed in the Provider Manual. When requesting continuing services, a provider must submit a beneficiary's treatment plan to OVHA. The treatment plan must include the medical and psychiatric history of the patient, recommended course of treatment, anticipated number and frequency of services, and such other relevant information as will fully substantiate the request for continuing services.

Payment for psychotherapy services rendered by an independently practicing psychologist will be at the lesser of usual and customary charge or the Medicaid reimbursement rate on file; for group therapy, at the lesser of usual and customary charge or the Medicaid reimbursement rate on file. Group therapy is limited to no more than three sessions per week. Reimbursement is limited to one session per day per group and no more than 10 patients in a group.

Where evidence of provider abuse of the Medicaid system is found, OVHA may take appropriate action as specified in M155-M155.6.

M811.2 Amphetamines and Appetite Depressants

Amphetamines and other psychomotor stimulants, straight or in combination, are covered only when:

a. Prior authorization has been granted by the OVHA Director or a designee, or

b. Used in the treatment of hyperkinesis in children between the ages of 3 and 18 years of age. No prior authorization is required.

Nonamphetamine-based weight-loss drugs (for example, Meridia™, Xenical™) are covered with prior authorization.

M811.3 Vitamins and Minerals

Generic pre-natal vitamins are covered for pregnant and lactating women when a physician certifies that condition on the prescription.

Single vitamins or minerals are covered when prescribed for the treatment of a specific disease; e.g. Vitamin B-12 in the treatment of certain types of anemia.

High potency multi-vitamins are covered only after prior authorization has been granted by the OVHA Director or a designee. Authorization will be granted only upon submission by a physician of pertinent clinical and diagnostic data indicating manifest vitamin deficiency.

M811.4 Other Preparations

The following classes of over-the-counter preparations are excluded from coverage:

- analgesics such as Alka Seltzer, Anacin, Aspergum, Aspirin, Bromo-Seltzer, Bufferin, Cope, Ecotrin, Excedrin, Measurin, and Tylenol;
- fecal softeners such as Colace, Dialose, Dorbane, D.S.S., Dulcolax, Peri-Colace, Regutol, and Surfak;
- laxatives and antidiarrheals such as Agoral, Alophen, Carter's Tablets, Cascara, Citrate of Magnesia, Correctol, Donnagel, Ex-Lax, Haley's M.O., Kaopectate, Kondremul, Metamucil, Milk of Magnesia, Mineral Oil, Phenolax, Psyllium Seed, Senokot, and Serutan;
- antacids and antiflatulents such as Amphojel, Di-Gel, Ducon, Gaviscon, Gelusil, Maalox, Mylanta, Mylicon, Riopan, Silain, and Titralac.

M811.4 Other Preparations (Continued)

Exception will be made for the above preparations only where the attending physician has prescribed in quantity as a part of the medical treatment of a specific disease; for example, analgesics for the relief of pains of arthritis, antacids for patients with peptic ulcers or when used for the patient to tolerate other therapeutic medications, and laxatives for the bedbound. A written request for exception and prior approval in such instances, with diagnoses and pertinent clinical data, should be directed to the Office of Vermont Health Access by the prescribing physician.

M812 Family Planning Items

Contraceptive drugs, supplies, and devices are covered when provided on a physician's order. Birth control pills may be dispensed in a quantity not to exceed a 92-day supply. Payments made for these items will be deemed to qualify for the increased federal financial participation contained in section l903 (a)(5) of the Social Security Act.

M812.1 Prescription Drugs for the Treatment of Sexual Dysfunction

Prescription drugs, such as but not limited to Caverject™,Viagra™, and Yohimbine™, whose primary purpose is the treatment of erectile or sexual dysfunction, are limited to four dosages (tablets or injections) per beneficiary per month.